



Provider Grievance Form

INSTRUCTIONS

CenCal Health makes a grievance resolution process available to providers in accordance with various regulations that govern the healthplan. These grievances, or disputes, may take various forms, including, but not limited to, the following: inquiries (a request for assistance, clarification, or information), appeals (requests to change a previous decision, i.e. regarding Authorization Requests, Medical Authorization Requests, or claims), or complaints (an expression of dissatisfaction). In order to be effectively addressed, we have provided this form for providers to use when submitting grievances to CenCal Health. If submitting a grievance, please complete this form, attach all supporting documentation, and clearly describe the reason for your grievance. Grievances lacking information required for resolution will be returned to you with a request for more information.

CenCal Health requests that you file an appeal only in situations where CenCal Health has received all documentation required to make a decision and you are now requesting reconsideration of that decision due to extenuating circumstances. Do not submit this form as an appeal if a claim was denied for lack of documentation, if your grievance concerns an issue that is older than 365 days from CenCal Health's last action, or if there has been a simple clerical error that could easily be resolved by our Claims staff.

If your grievance is a billing or payment dispute or claims appeal, please submit this completed form with all supporting documentation attached to:

*CenCal Health, 110 Castilian Drive, Goleta, CA 93117-3028,
ATTENTION: Adjudication Dept.*

The mailing address for submitting all other provider grievances is:

*CenCal Health, 110 Castilian Drive, Goleta, CA 93117-3028,
ATTENTION: Provider Services Dept.*

Please do not submit grievances via e-mail as the protections may not meet federal healthcare privacy standards and this method does not adequately allow for supporting documentation. CenCal Health will acknowledge receipt of your grievance within 15 business days and send a written resolution to your grievance within 45 business days after the date of receipt.

Provider Name:		Provider Tax ID#:				
		Provider License #:				
Provider Address:						
Provider Type: <input type="checkbox"/> PCP <input type="checkbox"/> Referral- Specialty _____ <input type="checkbox"/> Hospital <input type="checkbox"/> LTC <input type="checkbox"/> Pharmacy <input type="checkbox"/> DME- Type _____ <input type="checkbox"/> Other _____						
Name of person submitting grievance:		Relationship to provider: <input type="checkbox"/> Self <input type="checkbox"/> Office staff <input type="checkbox"/> Billing service <input type="checkbox"/> Other _____				
Address of person submitting grievance:			Phone #:			
Grievance Type: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> Inquiry <input type="checkbox"/> Benefit <input type="checkbox"/> Contract <input type="checkbox"/> Reimbursement Rate <input type="checkbox"/> Claims Adjudication (EOB assistance) <input type="checkbox"/> Other _____ </td> <td style="width: 33%; vertical-align: top;"> Appeal <input type="checkbox"/> Referral Authorization Request (RAF) <input type="checkbox"/> Authorization Request (AR) <input type="checkbox"/> Medical Authorization Form (MRF) <input type="checkbox"/> Claim <input type="checkbox"/> Other _____ </td> <td style="width: 33%; vertical-align: top;"> Complaint (against...) <input type="checkbox"/> Provider <input type="checkbox"/> Member <input type="checkbox"/> CenCal Health <input type="checkbox"/> MedImpact <input type="checkbox"/> PacifiCare Behavioral Health <input type="checkbox"/> Other _____ </td> </tr> </table>				Inquiry <input type="checkbox"/> Benefit <input type="checkbox"/> Contract <input type="checkbox"/> Reimbursement Rate <input type="checkbox"/> Claims Adjudication (EOB assistance) <input type="checkbox"/> Other _____	Appeal <input type="checkbox"/> Referral Authorization Request (RAF) <input type="checkbox"/> Authorization Request (AR) <input type="checkbox"/> Medical Authorization Form (MRF) <input type="checkbox"/> Claim <input type="checkbox"/> Other _____	Complaint (against...) <input type="checkbox"/> Provider <input type="checkbox"/> Member <input type="checkbox"/> CenCal Health <input type="checkbox"/> MedImpact <input type="checkbox"/> PacifiCare Behavioral Health <input type="checkbox"/> Other _____
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Member Name:		Member ID#:	Claim Control Number(s):			
DOS:						
Description of Dispute (please attach additional pages as needed and include all available supporting documentation):						